SOUTH CAROLINA BUDGET & CONTROL BOARD
EMPLOYEE INSURANCE PROGRAM
MoneyPlu$ FLEXIBLE SPENDING ACCOUNT
Change In Status (CIS) Form

PLAN YEAR: _____

Social Security Number	Name (Please Print) Last	First	MI

Home/Mailing Address	Street	City	State	Zip

TYPE OF CHANGE REQUESTED

Change Existing Account	Start Account	Terminate Account
__ Medical Spending Account __ Dependent Care Account	__ Medical Spending Account __ Dependent Care Account	__ Medical Spending Account __ Dependent Care Account

QUALIFIED CHANGE EVENTS (CHECK AND DATE ALL THAT APPLY)

CIS Effective date of Event

Event Date **Event**

_____ Marriage
_____ Birth
_____ Adoption
_____ Placement of Custody
_____ Spouse Ends Employment
_____ Spouse Begins Unpaid Leave

CIS Effective day after date of Event

Event Date **Event**

_____ Spoused Passed Away
_____ Dependent Passed Away

CIS Effective first of the month following Event

Event Date **Event**

_____ Dependent not Eligible (marriage, age, loss of dependent status)
_____ Spouse Begins Employment
_____ Spouse Ends Unpaid Leave
_____ Divorce
_____ Legal Separation
_____ Change in Day Care Provider
_____ Employee Begins Unpaid Leave
_____ Employee Ends Unpaid Leave
_____ Change from full- to part-time (self, spouse, dependent)
_____ Change from part- to full-time (self, Spouse, dependent)

PAYROLL CALCULATION SUMMARY

To be completed by Benefits Administrator	MEDICAL SPENDING ACCOUNT	DEPENDENT CARE ACCOUNT
A. Current Total Annual Contribution		
B. New Total Annual Contribution		
C. Amount Contributed Thus Far		
D. Amount Needed to Meet New Annual Goal [B minus C]		
E. Number of Paychecks Remaining		
F. New Per-Pay-Deduction Amount [D divided by E]		
Benefit Effective Date (refer to qualified change event above)		
Payroll Effective Date		

I certify that on the date(s) indicated, I incurred the Change in Status(s) checked above and therefore wish to change my plan elections as indicated. I understand that the change requested must be consistent with the Change in Status event and can only apply to the remaining portion of my period of coverage. I understand that the amount of salary deduction will include the items specified above and will continue in effect, unless I terminate employment or file an approved Change in Status with the Benefits Administrator within 31 days of the event. I understand and agree that my employer and Fringe Benefits Management Company, the contract administrator, will not incur any liability resulting from either my participation in any FSA or my failure to sign or accurately complete this enrollment form.

Employee Signature	Date

FOR OFFICE USE ONLY

Signature below affirms that the item(s) checked comply with IRS and Flexible Spending Account plan guidelines. This employee meets all eligibility requirements, and is eligible to participate in the Money Plu$ Program. Return processed CIS form via ☐ FAX ☐MAIL (check one).

Payroll Center/Agency	Mailing Address	City, State, Zip	Fax Number

Benefits Administrator Approval Signature	Date	Phone Number

*Please return within 24 hours of completion. The payroll change should not be made until you receive fax confirmation that the change has been made in Fringe Benefits Management Company's system. Return completed form via fax to 1-850-514-5805 or mail to FBMC, P.O. Box 1878, Tallahassee, Fl. 32303. If you have any questions you may contact our Customer Service Department, at 1-800-342-8017, for assistance. Please allow up to 10 business days for processing.

Date FBMC Received Approved CIS Form from BA _____ *Date FBMC Data Entered CIS Form* _____ *Date FBMC Sent Processed Form to BA* _____